



DEPARTMENT OF STATE

Washington, D.C. 20520

April 11, 1975

Grant  
# 1069-587161

Mr. Laurence Sickman  
Director  
William Rockhill Nelson  
Gallery of Art  
4525 Oak Street  
Kansas City, Missouri 64111

Dear Mr. Sickman:

Enclosed is the necessary insurance material to be used in administering the foreign visitors accident and sickness group insurance policy mentioned in Article V of Grant Agreement 1069-587161. Premiums for this policy are paid by the Department of State.

Each foreign visitor is to be given the following:

1. A brochure outlining the provisions and limitations of the policy.
2. A claim form to be completed by the visitor when required by medical treatment.
3. An insurance identification card to be carried by the visitor at all times. This card should be completed and signed by an appropriate representative of your organization.

An insurance report form must be completed for each visitor to be covered and submitted to this office. The pink copy of the form may be retained for your records.

If you desire further information concerning our insurance program, please call me (202-632-3386).

Sincerely yours,

*Henrietta T. Bachmann*  
Henrietta T. Bachmann  
Chief, Contract Negotiation  
and Compliance Branch  
Bureau of Educational and  
Cultural Affairs

Enclosures  
as stated.

CU/EX/BM:NWRunkles:lkf



**The Chinese Exhibition**

The Exhibition of Archaeological Finds of the People's Republic of China

The William Rockhill Nelson Gallery-Atkins Museum of Fine Arts

April 20th to June 8th, 1975

中華人民共和國出土文物展覽

May 28, 1975

Dear Maurice,

Enclosed is a copy of the letter Mr. Sickman received from the State Department concerning insurance for the curators. This letter should give you all the information necessary to obtain the insurance forms from State.

I suggest you write Ms Bachmann in the near future requesting the forms, because State will probably take a bit of time in getting them to you.

Good Luck.

Bob Friesner

*Bob*

*Letter to Maurice Tseng -  
Escort for the Curators  
in San Francisco*

**INSURANCE IDENTIFICATION CARD**

*Group Insurance Program Underwritten by*

**SUPREME LIFE INSURANCE COMPANY OF AMERICA**

3501 Dr. Martin Luther King Jr. Drive  
Chicago, Illinois 60653

**POLICY No. GBP-700 insures the following named individual:**

**PROGRAM** \_\_\_\_\_

**Inception Date of Coverage** \_\_\_\_\_

**Expiration Date of Coverage** \_\_\_\_\_

**Name** \_\_\_\_\_

**Present Address:** \_\_\_\_\_

**Programming Agency:** \_\_\_\_\_

**Home Country:** \_\_\_\_\_

**Signature of Agency Representative:** \_\_\_\_\_

4-46 (12/74)

This card identifies the person whose name appears on the reverse side as a participant in the Accident and Sickness Insurance Program which the United States Government has arranged for certain individuals. Particulars of the insurance are offered in a descriptive brochure which has been presented to each participant.



*Program of*

**ACCIDENT  
and  
SICKNESS  
GROUP INSURANCE**

*Provided by*

**UNITED STATES GOVERNMENT  
DEPARTMENT OF STATE  
BUREAU OF EDUCATIONAL AND CULTURAL AFFAIRS**

*Grantees coming to the United States or its possessions or territories or going abroad for training, lecturing, teaching, studying or related activities under the sponsorship of the Bureau of Educational and Cultural Affairs are insured under this plan (Policy GBP-700), at no cost to the grantee, while participating in a sponsored grant program and while travelling to and from their homes.*

*Underwritten by*

*Insurance* **S**UPREME **L**IFE  
*Company of America*

Administrator's Office: INVESTMENT BUILDING, WASHINGTON, D.C. 20005  
Brokers INTERNATIONAL UNDERWRITERS, INC.  
Investment Building, Washington, D.C.





DEPARTMENT OF STATE

Washington, D.C. 20520

To the Grantee and Attending Doctor:

I am pleased to inform you that the Department of State will assume the cost of health and accident insurance for grantees sponsored by the Bureau of Educational and Cultural Affairs during the time of their participation in the exchange program. Medical and other expenses due to accident or illness will be paid under an insurance contract arranged with the the Supreme Life Insurance Company of America.

If the grantee suffers an accident or illness requiring medical attention, this brochure, his identification card and a claim form should be presented to the appropriate medical attendant or facility. The brochure and identification card should then be returned to the grantee and kept in his possession at all times.

The grantee is required to pay the first \$10.00 of expenses with respect to each illness or accident. The medical attendant or facility should submit itemized bills and a completed claim form to the Supreme Life Insurance Company of America, 3501 Dr. Martin Luther King Jr. Drive, Chicago, Illinois 60653. Reasonable medical expenses (i.e. those fees normally charged in the local community) when accompanied by a completed claim form and itemized bills, will be processed promptly and payment will be made to the individual or facility indicated on the claim form.

Insurance coverage commences on the date the grantee leaves home, continues in effect while he is participating in the program, and remains in effect during direct return travel. Insurance coverage during private travel or stay must be purchased at the grantee's personal expense.

I sincerely appreciate your assistance in furthering the objectives of the Educational and Cultural Exchange Program and in advancing international cooperation and understanding.

Sincerely yours,

John Richardson, Jr.  
Assistant Secretary for  
Educational and Cultural Affairs



## BENEFITS OF THE PROGRAM

### FOR MEDICAL EXPENSE ACCIDENT AND SICKNESS

When injury or sickness shall require treatment by a doctor, confinement within an infirmary or a legally constituted hospital, employment of a qualified nurse, x-ray examination, use of an ambulance, or therapeutic services, laboratory services, supplies or medicines deemed necessary by the attending doctor, dental care for the emergency alleviation of pain and including cosmetic dentistry, false teeth and bridgework when necessitated by injury to the insured, and the replacement of eyeglasses, contact lenses and/or glass eye when broken as the result of a bona fide accident, the carrier will pay for the expenses actually incurred therefor by the insured over and above the first ten dollars (\$10.00) for treatment during the ensuing 52 weeks from the date of the accident or the commencement of the sickness but not to exceed \$2,000.00 in the aggregate, as the result of any one injury or sickness.

### PREPARATION AND TRANSPORTATION OF REMAINS

In the event of the death of the insured hereunder occurring within the term of the policy, the carrier agrees to pay the actual charges for preparing and transporting to their former homes (in accordance with applicable international requirements) the remains of any such person who may die while away from their home, but not to exceed \$1,500. (These benefits are in addition to other policy benefits).

### FOR SPECIFIC ACCIDENT LOSSES

Indemnity for bodily injury sustained during the term of the policy resulting in one or more of the losses specified below and such loss occurring within 52 weeks from date of accident, shall be subject to the following provisions and limitations; For loss of:

A. Both hands or both feet or sight of both eyes .....	\$3,000.00
B. One hand and one foot .....	\$3,000.00
C. Either hand or foot and sight of one eye .....	\$3,000.00
D. Either hand or foot .....	\$1,500.00
E. Sight of one eye .....	\$1,000.00
F. Thumb and index finger of either hand .....	\$ 750.00

Loss shall mean with regard to hands and feet, dismemberment by severance through or above wrist or ankle joints; with regard to eyes, entire and irrecoverable loss of sight; with regard to thumb and index finger, severance through or above metacarpophalangeal joints.

If the insured has suffered prior to the effective date of the insurance under the policy, and thereafter suffers the loss of one hand or one foot or the sight of one eye, the benefit payable for any subsequent loss shall be the benefit provided above for such subsequent loss without reference to any previous loss.

### LIMITATIONS OF COVERAGE

The policy does not cover:

1. Such injury or such sickness for which any benefits are provided by Workmen's Compensation or occupational disease acts, welfare programs or any other valid and collectible insurance policy.
2. Such injuries or such sickness contracted or sustained by the insured (a) while in active duty in military or naval service of any country at war, or (b) which is the result of, or is caused by, any act of war.
3. Pregnancy (including resulting childbirth or miscarriage or any complication of pregnancy).
4. Dental care; unless required by an accident to the insured. The carrier may reject any claim for dental treatment when not accompanied by proof of a bona fide accident to the insured. However, the emergency alleviation of pain shall be covered herein. Pyorrhea is a disease and falls under sickness expense indemnity.
5. Routine physical or any other examinations where there are no objective indications of impairment in normal health.
6. Eye examinations, fittings and prescriptions. However, in the event eye glasses, contact lenses, and/or glass eye become broken or destroyed as the result of a bona fide accident to the individual, the carrier will replace such eye glasses, contact lenses and/or glass eye as may be prescribed by an optometrist, oculist or ophthalmologist.

### EFFECTIVE DATE OF COVERAGE

Coverage under the policy for the insured shall be effective on the date he leaves his home for the purpose of participating in the program administered by the Bureau of Educational and Cultural Affairs of the Department of State and shall continue in force while the insured is in the Host Country for such participation and while directly enroute to his home.

### DEFINITIONS

1. "Injury" shall mean accidental bodily injury sustained and requiring medical treatment by the insured during the term of the policy.
2. "Sickness" shall mean sickness, illness or disease requiring medical treatment by the insured during the term of the policy.
3. "Hospital" shall mean a legally constituted and lawfully operated hospital which accepts registered in-patients.
4. "Doctor" shall mean a professionally qualified individual duly licensed to practice medicine (including but not limited to surgery, dentistry, and ophthalmology) in the state or country in which he resides or practices.



## BENEFITS OF THE PROGRAM

### STATE OF THE PROGRAM

#### LIMITATION OF COVERAGE

The policy does not cover:

1. Death benefit or cash advance for which any proceeds are payable by the Insurance Company under an accelerated benefit rider unless the insured is terminally ill and confined to his home by a physician.

2. Death benefit or cash advance contracted or assigned by the insured (a) while in active military service or (b) while in active service of the United States Armed Forces or (c) while in active service of the United States Coast Guard or (d) while in active service of the United States Navy or (e) while in active service of the United States Marine Corps or (f) while in active service of the United States Air Force or (g) while in active service of the United States Space Force or (h) while in active service of the United States Coast Guard or (i) while in active service of the United States Navy or (j) while in active service of the United States Marine Corps or (k) while in active service of the United States Air Force or (l) while in active service of the United States Space Force.

3. Payment (including the cash advance) to the insured or his estate (a) if the insured is a minor or (b) if the insured is a person who is not a resident of the United States or (c) if the insured is a person who is not a citizen of the United States or (d) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (e) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (f) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (g) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (h) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (i) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (j) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (k) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (l) if the insured is a person who is not a resident of the United States and is not a citizen of the United States.

4. Payment (including the cash advance) to the insured or his estate (a) if the insured is a minor or (b) if the insured is a person who is not a resident of the United States or (c) if the insured is a person who is not a citizen of the United States or (d) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (e) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (f) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (g) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (h) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (i) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (j) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (k) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (l) if the insured is a person who is not a resident of the United States and is not a citizen of the United States.

5. The amount payable to the insured or his estate (a) if the insured is a minor or (b) if the insured is a person who is not a resident of the United States or (c) if the insured is a person who is not a citizen of the United States or (d) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (e) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (f) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (g) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (h) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (i) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (j) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (k) if the insured is a person who is not a resident of the United States and is not a citizen of the United States or (l) if the insured is a person who is not a resident of the United States and is not a citizen of the United States.

## REPORTING OF CLAIMS

Claim forms, properly completed with all applicable bills—and all correspondence relating to claims—should be directed to:

**SUPREME LIFE**  
*Insurance Company of America*

3501 Dr. Martin Luther King Jr. Drive  
Chicago, Illinois 60653

### THIS PLAN ADMINISTERED BY:

INTERNATIONAL UNDERWRITERS, INC.  
INSURANCE BROKERS AND CONSULTANTS  
INVESTMENT BUILDING, WASHINGTON D.C. 20005



**SUPREME LIFE**  
*Insurance Company of America*  
Chicago, Illinois 60653

**ATTENDING PHYSICIAN'S STATEMENT**

**PART B — TO BE COMPLETED IN DETAIL BY ATTENDING PHYSICIAN — PLEASE PRINT**

1. Patient's name ..... Age .....
  2. Nature of sickness or injury (Describe complications, if any) .....  
.....
  3. Is disability due to pregnancy? Yes ..... No .....  
If "Yes", what was the approximate date of commencement of pregnancy? ..... 19 .....
  4. Nature of surgical or obstetrical procedure, if any (Describe fully) .....  
.....
  5. Date performed ..... 19 .....  
Charge for this procedure \$ .....  
Where performed ..... If in hospital, in-patient ..... out-patient .....
  6. Give dates of treatments: Charge Per Call  

Office .....	\$ .....
Home .....	\$ .....
Hospital .....	\$ .....
LESS DEDUCTIBLE	
	10.00
	\$ .....
  7. What other services, if any, did you provide patient? (Itemize, giving dates and fees) .....  
.....  
.....
  8. The patient has been continuously disabled (unable to work) from ..... 19 ..... through ..... 19 .....  
If still disabled, when should patient be able to return to work? ..... 19 .....
  9. Has patient been discharged from your care? Yes ..... No .....
  10. Remarks .....  
.....
  11. To what other companies or associations are you reporting this loss ? .....  
.....  
.....
- .....  
Doctor's Name (Please Print) Doctor's Signature  
.....  
Doctor's Address (Please Print) Date Report Completed

NOTE: POLICY PROVIDES BENEFITS OVER AND ABOVE THE  
FIRST TEN DOLLARS (\$10.00) OF ACTUAL EXPENSE.



## INSTRUCTIONS

- Supreme Life Insurance of America**  
**3501 Dr. Martin Luther King Jr. Drive**  
**Chicago, Illinois**  
**60653 USA**

Name of School .....  
 Present Address .....  
 Mailing Address .....  
 Programming Agency ..... Home Country .....

- .....  
Signature of Participant

Present Address . . . . . Signature . . . . .  
 . . . . . Tax Identification  
 . . . . . No. . . . .  
 Date . . . . .

**PLEASE SUBMIT ALL APPLICABLE MEDICAL BILLS**